



REFUGEE HEALTH ASSESSMENT FORM

To be completed within 180 days of U.S. arrival or asylum date.

Person completing form: _____

Client's RMA Card present? ☐ Yes ☐ No

Initial Screening Date (mm/dd/yyyy): _____

Final Screening Date (mm/dd/yyyy): _____

Interpreter Used? ☐ Yes ☐ No☐ Telephonic ☐ Bilingual LHD Staff ☐ Contracted ☐ Other

DEMOGRAPHICS

Name (Last, First, Middle)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Alien #
DOB (mm/dd/yyyy)	Age	Country of Birth	Name of Refugee Camp
County of Residence	Resettlement/Volunteer Agency	Agency performing health screen	Primary language spoken
Ethnicity (Hispanic or Latino) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Race (select one or more, if multiracial, check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		

IMMIGRATION STATUS

<input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Cuban/Haitian <input type="checkbox"/> Parolee <input type="checkbox"/> Amerasian <input type="checkbox"/> Victim of Trafficking <input type="checkbox"/> Special Immigrant Visa		
Migration Status <input type="checkbox"/> Primary <input type="checkbox"/> Secondary (within U.S.)	Date of arrival in the U.S. (mm/dd/yyyy)	If asylee, date asylum granted (mm/dd/yyyy)

SCREENING INFORMATION

General Health Screening

Waiver (please list the condition) ☐ Class A _____ ☐ Class B _____ ☐ Class B1 TB ☐ Class B2 TB ☐ Class B3 TB

Medical history reviewed? (✓ one)

☐ Yes☐ No

Pregnancy Test? (✓ one)

☐ Negative☐ Positive☐ Not applicable☐ Not evaluated

General physical exam conducted? (✓ one)

☐ Yes☐ No☐ Referred

Date of CBC with differential (mm/dd/yyyy) _____

Hemoglobin _____ g/dL

Hematocrit _____ %

Eosinophil count _____ cells/ μ L

Total Cholesterol _____ mg/dL

HDL Cholesterol _____ mg/dL

Iron _____ μ g/dL☐ Normal☐ Abnormal☐ Not applicable☐ Not evaluated

Urinalysis

☐ Normal☐ Abnormal☐ Not evaluated

Comp. Metabolic Panel

☐ Evaluated☐ Not evaluated

(Values only needed for abnormal test results) (mEq/L is equivalent to mmol/L)

Albumin: ☐ Normal ☐ Abnormal _____ g/dLAlkaline phosphatase (ALP): ☐ Normal ☐ Abnormal _____ IU/LALT (alanine aminotransferase): ☐ Normal ☐ Abnormal _____ IU/LAST (aspartate aminotransferase): ☐ Normal ☐ Abnormal _____ IU/LBUN (blood urea nitrogen): ☐ Normal ☐ Abnormal _____ mg/dLCalcium: ☐ Normal ☐ Abnormal _____ mg/dLChloride: ☐ Normal ☐ Abnormal _____ (mEq/L) or (mmol/L)Carbon Dioxide: ☐ Normal ☐ Abnormal _____ (mEq/L) or (mmol/L)Creatinine: ☐ Normal ☐ Abnormal _____ mg/dLGlucose: ☐ Normal ☐ Abnormal _____ mg/dLPotassium: ☐ Normal ☐ Abnormal _____ (mEq/L) or (mmol/L)Sodium: ☐ Normal ☐ Abnormal _____ (mEq/L) or (mmol/L)Total bilirubin: ☐ Normal ☐ Abnormal _____ mg/dLTotal protein: ☐ Normal ☐ Abnormal _____ g/dLFor the following, please provide a current assessment (please do not fill in information as abstracted from the overseas record):

Height _____ ft. _____ in. (list in feet and inches) Weight _____ (list in pounds)

Blood Pressure

☐ Normal (for age)☐ Abnormal

Vision

☐ Evaluated☐ Not evaluated☐ Referred

Hearing

☐ Evaluated☐ Not evaluated☐ Referred

Oral Health

☐ Evaluated☐ Not evaluated☐ Referred

Multivitamins Provided

☐ Yes☐ No☐ Declined

Tuberculosis Screening Tuberculin Skin Test (✓ one) <i>(give regardless of BCG history)</i> Result: _____ mm <input type="checkbox"/> Patient declined test <input type="checkbox"/> Placed, not read <input type="checkbox"/> Documented prior positive Blood Assay for <i>M. tuberculosis</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable If Yes, which test? <input type="checkbox"/> Quantiferon: Result _____ IU/mL <input type="checkbox"/> T-spot: Result _____ spots Interpretation of QFT or T-spot <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate	Chest X-Ray: (taken in U.S.) (✓ one) Date of X-Ray: _____ (mm/dd/yyyy) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, not consistent with TB <input type="checkbox"/> Abnormal, stable, indicative of old TB <input type="checkbox"/> Abnormal, cavitary <input type="checkbox"/> Abnormal, non-cavitary, consistent with TB <input type="checkbox"/> Pending <input type="checkbox"/> Patient declined CXR <input type="checkbox"/> Not applicable TB status (✓ one) <input type="checkbox"/> Active <input type="checkbox"/> Suspect <input type="checkbox"/> Latent <input type="checkbox"/> Old TB <input type="checkbox"/> TB not identified	TB Therapy: (✓ one) <input type="checkbox"/> Treatment for suspected or confirmed active TB Date Started: _____ <input type="checkbox"/> Treatment for Latent TB infection (LTBI) prescribed: Date Started: _____ <input type="checkbox"/> No TB or LTBI treatment; Reason: <input type="checkbox"/> Treatment not indicated <input type="checkbox"/> Completed treatment overseas <input type="checkbox"/> Pregnancy <input type="checkbox"/> Patient declined treatment <input type="checkbox"/> Medical condition other than pregnancy <input type="checkbox"/> Patient lost in follow-up <input type="checkbox"/> Further evaluation pending <input type="checkbox"/> Other: _____
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Blood Lead Level Screening (Recommended for all children ≤ 16 years of age)			
Was blood lead level testing provided? (✓ one) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable			
Date of blood draw: _____ (mm/dd/yyyy)	Result: _____ (µg/dL)	Date of follow-up test: _____ (mm/dd/yyyy)	Result: _____ (µg/dL)
If result was ≥ 5 µg/dL, was patient referred? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Immunization Record Review overseas medical exam (DS-2054) and the Vaccination Documentation Worksheet (DS -3025) if available and document immunization dates. For measles, mumps, rubella, varicella, and HBV: indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease. For all other immunizations: update series, or begin primary series if no immunization dates are found. Please follow the current Maryland Childhood and Adult Immunization Schedules <http://phpa.dhmm.maryland.gov/OIDEOR/IMMUN/>.

<input type="checkbox"/> Immunization records available & reviewed		<input type="checkbox"/> Immunization records not available					
Vaccine-Preventable Disease/ Immunization	✓ if there is lab evidence of immunity; immunization not needed	Immunization Date(s)					
		Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Measles (or MR or MMR)							
Mumps (or MMR)							
Rubella							
Varicella (VZV)							
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, Tdap)							
Diphtheria-Tetanus (Td, DT)							
Polio (IPV, OPV)							
Hepatitis B (HBV)							
<i>Haemophilus influenzae</i> type b (Hib)							
Influenza							
Pneumococcal							
Other _____							

Hepatitis B Screening			
<input type="checkbox"/> Tested for Hepatitis B? (✓ one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused <input type="checkbox"/> Evaluated, but testing not required
<input type="checkbox"/> Anti-HBs (✓ one)	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive (If positive, patient is immune.)	
<input type="checkbox"/> HBsAg (✓ one)	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	
<input type="checkbox"/> Anti-HBc (total)	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	
<input type="checkbox"/> IgM anti-HBc	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	
<i>(If positive HBsAg, patient is infected with HBV and is infectious to contacts; needs HBV counseling and all household contacts must be screened)</i>			
If positive HBsAg, were all household contacts screened?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, were all susceptibles started on vaccine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Sexually Transmitted Infections Screening (✓ one for each of the following)			
Overseas syphilis screening results reviewed? (only necessary for those ≥ 15 years of age) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available			
<i>**If positive, syphilis testing must be repeated in the U.S.</i>			

Sexually Transmitted Infections Screening Continued:

Syphilis screening test in U.S. (VDRL/RPR) Date: _____ ☐ Negative ☐ Positive ☐ Not applicable ☐ Not Done
Syphilis confirmation test in U.S. (EIA/FTA/TPPA) Date: _____ ☐ Negative ☐ Positive ☐ Not applicable ☐ Not Done
 If diagnosed with syphilis, was the patient treated? ☐ Yes ☐ No ☐ Referred

Tested for Chlamydia? ☐ Yes (Date: _____) ☐ No **Result:** ☐ Negative ☐ Positive
 If positive, was the patient treated? ☐ Yes ☐ No ☐ Referred
Tested for Gonorrhea? ☐ Yes (Date: _____) ☐ No **Result:** ☐ Negative ☐ Positive
 If positive, was the patient treated? ☐ Yes ☐ No ☐ Referred
Tested for HIV? ☐ Yes (Date: _____) ☐ No **Result:** ☐ Negative ☐ Positive
 If positive, was the patient treated? ☐ Yes ☐ No ☐ Referred

Intestinal Parasite Screening (✓ one for each of the following)**Was testing for parasites done?** (✓ one)

- ☐ Evaluated, but testing not required
☐ Stool kits offered, but not returned
☐ Tested, results pending
☐ Tested, no parasites found

☐ Tested, parasite(s) found: (✓ all that apply)

<input type="checkbox"/> Ascaris Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred	<input type="checkbox"/> Schistosoma Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred
<input type="checkbox"/> Blastocystis Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred	<input type="checkbox"/> Strongyloides Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred
<input type="checkbox"/> Clonorchis Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred	<input type="checkbox"/> Trichuris Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred
<input type="checkbox"/> E. histolytica Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred	<input type="checkbox"/> Other _____ Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred
<input type="checkbox"/> Giardia Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred	_____ Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred
<input type="checkbox"/> Hookworm Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred	_____ Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Referred

Intestinal Parasite Presumptive Treatment (When given overseas, pre-departure presumptive treatment is listed on the Alien Info. coversheet)

	Strongyloidiasis			Schistosomiasis			Soil-transmitted Helminths		
Documented Pre-departure Presumptive Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Post-arrival Presumptive Treatment Given	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Mental Health Screening (only necessary for those ≥18 years of age)

Mental Health Screening? ☐ Yes (Date: _____) ☐ No ☐ Not applicable ☐ Declined

Person administering Mental Health Screening: _____ Name of Interpreter for RHS-15: _____

Symptoms Total Score (Items 1-14 from RHS-15) _____

Distress Thermometer Score (Item 15 from RHS-15) _____

Patient educated on score? ☐ Yes ☐ No

Needs Referral? ☐ Yes ☐ No

Referral Accepted? ☐ Yes ☐ No

(If NO, check appropriate reason) ☐ Patient doesn't believe services are needed

☐ Patient did not specify reason

☐ Patient wants to keep problems private

☐ Other (please specify) _____

☐ Patient is planning to move

Referral due to: (✓ all that apply) ☐ Score ☐ Overseas Diagnosis ☐ Observation ☐ Crisis

If crisis condition, was patient referred during visit? ☐ Yes ☐ No

Crisis Referral made to whom: _____

Any mental health conditions identified in overseas documentation? ☐ Yes ☐ No ☐ Not Available

(If YES, please provide details in Mental Health Comments section.)

Mental Health Comments: _____

Referrals Provided (✓ all that apply)

<input type="checkbox"/> Primary Care Provider	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> WIC	<input type="checkbox"/> Neurology	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Hearing	<input type="checkbox"/> Endocrinology
<input type="checkbox"/> Family Planning	<input type="checkbox"/> GI	<input type="checkbox"/> Urology	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> General Medicine	<input type="checkbox"/> Other Referral